M) Ancillary Services Reimbursement

Ancillary services provided to Medicaid recipients are allowable costs, and thus, reimbursable under both the Medicare and Medicaid Programs. Medicare reimburses these costs outside of the overall routine per diem rate while Medicaid reimburses these costs as a part of the overall routine per diem rate. Ancillary services which are reimbursed by Medicare include: physical therapy, speech therapy, oxygen therapy, occupational therapy, medical supplies, PEN therapy and other special services. Effective January 1, 1995, in order to avoid dual reimbursement of these costs from both the Medicare and Medicaid Programs, the SCDHHS will only include the costs of the Medicaid recipients' ancillary services which are not reimbursed by the Medicare Program in the facility's Medicaid reimbursement rate. However, when ancillary service costs are reimbursed as part of routine costs by Medicare (e.g. PEN Therapy), these costs will continue to be treated as allowable costs in the facility's Medicaid reimbursement rate. Therefore, only those costs which are reimbursed outside of the overall routine per diem rate by Medicare will be removed from allowable costs for Medicaid rate setting purposes. The ancillary services costs that will be excluded from allowable costs will consist of direct costs only. No indirect costs associated with the removal of ancillary services will be removed from allowable costs in order to encourage Medicare participation.

For state operated long term care facilities which are reimbursed retrospectively their total allowable costs, no adjustment to the Medicaid rate will be made to ancillary services (including specialty beds) to adjust for dual reimbursement by both the Medicare and Medicaid Programs. Instead, Medicare Part A and Part B ancillary services cost settlements will be made upon submission of the annual FYE June 30 cost reports in accordance with the cost reporting schedules.

Pursuant to the above, it shall be the responsibility of the provider to bill the Medicare Program for the reimbursement of covered ancillary services provided to dual eligible recipients. Failure to implement billing procedures by January 1, 1995 will result in an adjustment to allowable cost.

N) Eden Alternative Expenses

The costs incurred by nursing facilities which participate in adopting the Eden Alternative concept will be considered an allowable cost for Medicaid rate setting purposes. The goals of the Eden Alternative are to improve the quality of life in nursing facilities, and transform the conventional nursing facility into a vibrant human habitat for its residents. The incorporation of gardens, animals, birds, and children into the daily activities of the nursing facility residents assists in meeting these goals.

As with all other allowable Medicaid costs, these costs will be subject to reasonableness and must be related to patient care. Additionally, Eden Alternative expenses must be offset by grant income. Costs associated with fund raising activities applicable to the Eden Alternative concept or any other fund raising program will not be considered an allowable cost for Medicaid rate setting purposes.

H. Payment Determination for ICF/MR's

1. All ICF/MR's shall apply the cost finding methods specified under 42 CFR 413.24(d) (1998) to its allowable costs for the cost reporting year under the South Carolina State Plan. ICF/MR facilities will not be subject to the allowable cost definitions R (A) through R (K) as defined in the plan.

2. All State owned/operated ICF/MR's are required to report costs on the Medicare Cost Reporting Form SSA 2552. For cost reporting periods beginning on or after July 1, 1986, all other ICF/MR's which are not operated by the State (S.C. Department of Disabilities and Special Needs) will file annual financial and statistical report forms supplied by the Medicaid Agency. All cost reports must be filed with the Medicaid Agency within one hundred twenty (120) days from close of each fiscal year.

3. ICF/MR's will be reimbursed on a retrospective cost related basis as determined in accordance with Medicare (Title XVIII) Laws, Regulations, and Policies adjusted for services covered by Medicaid (Title XIX).

Items of expense incurred by the ICF/MR facility in providing care are allowable costs for inclusion in the facility's cost report. These allowable costs are defined as items of expense which the provider may incur in meeting the definition of intermediate care or any expenses incurred in complying with state licensing or federal certification requirements.

Medicaid payment to the ICF/MR includes, but is not limited to, reimbursement for the following services:

a) Room and board including all of the items necessary to furnish the individual's room (luxury items/fixtures will not be recognized as an allowable cost). 42 CFR §483.470(b), (c), (d), (e), (f), and (g)(1) -(1998).

b) Direct care and nursing services as defined for each living unit of the facility. 42 CFR §483.460(c) - (1998).

c) Training and assistance as required for the activities of daily living, including, but not limited to, toileting, bathing, personal hygiene and eating as appropriate. 42 CFR §483.440(a) - (1998).

d) Walkers, wheelchairs, dental services, eyeglasses, hearing aids and other prosthetic or adaptive equipment as needed. If any of these services are reimbursable under a separate Medicaid program, the cost will be disallowed in the cost report (effective for cost reporting periods beginning July 1, 1989).

I. Payment for Swing-Bed Hospitals

Effective July 1, 1989, the South Carolina Medicaid Program will participate in the provision of nursing facility services in swing bed hospitals. A rate will be determined in accordance with the payment methodology as outlined in this state plan, adjusted for the following conditions:

A) Effective October 1, 1992, all nursing facilities in operation will be used in the calculation of the rate.

B) The rate excludes the cost associated with therapy services.

C) The rate reflects a weighted average rate using the state's prior FYE June 30 Medicaid permit days. Effective July 1, 1991, projected Medicaid days were used.

J. Intensive Technical Services Reimbursement

Effective July 1, 1989, an enhanced rate of $150 per patient day may be available for nursing facility recipients who require more intensive technical services (i.e., those recipients who have extreme medical conditions which requires total dependence on a life support system). Effective December 1, 1990, this rate will be $180. This rate was determined through an analysis of costs of 1) a small rural hospital located in South Carolina who would set up a small ward to provide this level of service and 2) contracting with an out-of-state provider which has established a wing in a nursing facility to deliver this type of service. This set per diem rate will represent payment in full and will not be cost settled. Providers receiving payment for intensive technical services patients will be required to step down cost applicable to this nonreimbursable cost center in accordance with item I(C) of this plan, upon submission of their annual cost report.

K. Essential Public Safety Net Nursing Facility Supplemental Payment

For nursing facility services reimbursed on or after January 1, 2002, qualifying Medicaid nursing facilities shall receive a Medicaid supplemental payment (in addition to the per diem payment). These payments will ensure the continued existence and stability of these core providers who serve the Medicaid population. The qualifications, upper payment limit calculation, and payment methodology are described below.

(1) Qualifications

In order to qualify for a supplemental payment as an Essential Public Safety Net nursing facility, a nursing facility must meet all of the following criteria:

a) The nursing facility is a non-state owned public nursing facility;
b) The nursing facility is located in the State of South Carolina;
c) The nursing facility is licensed as a nursing facility by the State of South Carolina and is a current Medicaid provider;

and one of the following criteria:

(i) The nursing facility is hospital based; or
(ii) The nursing facility is leased and operated by a hospital; or
(iii) The nursing facility's total licensed beds is in excess of 300 beds.

(2) Upper Payment Limit Calculation

The upper payment limit effective January 1, 2002 for Essential Public Safety Net nursing facilities will be calculated using the Medicaid frequency distribution of all licensed South Carolina non-state owned public nursing facilities which contract with the South Carolina Medicaid Program. This frequency distribution will be determined using the Medicaid MDS assessments completed during the most recently completed state fiscal year (i.e. July 1 through June 30) prior to the effective date of the plan amendment. The results of each nursing facility's Medicaid frequency distribution will then be applied to the total Medicaid patient days (less coinsurance days) paid to the nursing facility during the most recently completed state fiscal year in order to allocate the Medicaid days across the 44 Medicare RUG categories. The applicable Medicare rates for the payment year for each RUG category will be applied against the Medicaid days for each RUG category, and then summed, to determine the maximum upper payment limit to be used in the determination of the Essential Public Safety Net nursing facility payments.

Until such time that the Medicaid frequency distribution analysis has been run and analyzed for all of the licensed South Carolina non-state owned public nursing facilities which contract with the South Carolina Medicaid Program, the SCDHHS will calculate interim Essential Public Safety Net nursing facility payments. The interim upper payment limit will be calculated using Medicaid days (less coinsurance days) paid during the most recently completed state fiscal year prior to the effective date of the plan amendment and the Medicare RUG category IB2 rate in effect during the payment year. Once the final upper payment limit calculation has been determined based upon the Medicaid frequency distribution analysis described above, a reconciliation will take place between the interim and final Essential Public Safety Net nursing facility payments, and payments adjusted accordingly.

In order to adjust for program differences between the Medicare and Medicaid payment programs, the SCDHHS will calculate Medicaid payments in accordance with Section K(3)(b) of the plan.

(3) Payment Methodology

Subject to compliance with the March 13, 2001 Medicaid upper payment limit rules and other applicable regulations at 42 CFR Part 447, the South Carolina Department of Health and Human Services will make a supplemental Medicaid payment in addition to the standard nursing facility reimbursement to qualifying Essential Public Safety Net nursing facilities. Such payments will be made on a quarterly, or other basis after services have been furnished (e.g. semi-annually or annually). The payment methodology is described as follows:

a) The upper payment limit for all licensed South Carolina non-state owned public nursing facilities which contract with the South Carolina Medicaid Program will be computed as described under section K(2) above.
b) Medicaid reimbursement payments for all licensed South Carolina non-state owned public nursing facilities which contract with the South Carolina Medicaid Program will be computed using the UPL Medicaid days. The Medicaid reimbursement payments will incorporate the gross per diem payments based upon the Medicaid rate(s) in effect during the payment period as computed in accordance with the state plan, pharmacy payments through the ARM Program (on a per patient day basis), and estimated lab, x-ray and ambulance payments (on a per patient day basis).
c) The sum of the upper payment limit as described in K(3)(a) will be reduced by the sum of the Medicaid reimbursement payments as described in K(3)(b) to determine the amount of the upper payment limit pool payments to be paid to the qualifying Essential Public Safety Net nursing facilities (as defined in section K(1)).
d) Each qualifying Essential Public Safety Net nursing facility's supplemental payment will be calculated by taking the upper payment limit pool as described in K(3)(c) and multiplying by each Essential Public Safety Net nursing facility's percentage of unreimbursed UPL cost to total unreimbursed UPL cost of the Essential Public Safety Net nursing facilities.

The total payments made to the licensed South Carolina non-state owned public nursing facilities that contract with the South Carolina Medicaid Program, including the Essential Public Safety Net nursing facility supplemental payments, will not exceed the aggregate Upper Payment Limit amount for the non-state owned public nursing facilities. Additionally, the Essential Public Safety Net nursing facility supplemental payments will not be subject to the lower of costs or charges limitation.

L. Payment for Out-of-State Long Term Care Facilities

In order to provide services to the South Carolina Medicaid patients awaiting placement into a nursing facility, the agency will contract with out-of-state facilities at the other states' Medicaid reimbursement rate. The agency will use the out-of-state facility's survey conducted by their survey and certification agency for our survey and certification purposes. Placement of a South Carolina Medicaid recipient into an out-of-state facility will only occur if a bed is unavailable in South Carolina. No year end South Carolina Medicaid long term care cost report will be required from the participating out-of-state facilities.

M. Payment Assistance

The Medicaid Agency will pay each Provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the Provider under the Plan according to the methods and standards set forth in Section IV of this attachment.

N. Upper Limits

1. The Medicaid Agency will not pay more than the provider's customary charge for private-pay patients except public facilities that provide services free or at a nominal charge. These facilities will be reimbursed on a reasonable cost related basis.

2. Any limitation on coverage of cost published under 42 CFR 413.30 (1998) and 413.35 (1998) will be applied to payments for long-term care facility services.

3. The cost of services, facilities and supplies furnished by organizations related by common ownership or control will not exceed the lower of the cost to the organization or the price of comparable services, facilities or supplies purchased elsewhere. The Medicaid Agency's cost report requires related organizations and costs to be identified and certified.

4. The Medicaid Agency may not pay more in the aggregate for long term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement. If it is determined that SCDHHS is paying more in the aggregate for long term care services, then the Medicaid rate for each facility will be limited to the Medicare rate retroactive to the beginning of the contract period.

O. Provider Participation

Payments made under this State Plan are designed to enlist participation of a sufficient number of Providers of services in the program, so that eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public. In accordance with the Balanced Budget Act of 1997, the state has provided for a public process in which providers, beneficiaries and their representatives, and other concerned state residents are given the reasonable opportunity to review and comment on the determination of rates under this plan.

P. Payment in Full

Participation in the program shall be limited to Providers of services who accept, as payment in full, the amounts paid in accordance with the provisions of this attachment for covered services provided to Medicaid recipients in accordance with 42 CFR 447.15 (1998).

Q. Medicare Part A Coinsurance Days

Effective for dates of service beginning December 1, 2001, the South Carolina Department of Health and Human Services (SCDHHS) will no longer reimburse Medicaid contracting nursing facilities for Medicare Part A coinsurance days (Swing Bed Hospitals are exempted from this provision).

R. Allowability of Certain Costs

A) Auto Expense:

Allowable costs shall not include actual costs of administrative vehicles used for business purposes or regular vehicles used for patient care related activities (depreciation, maintenance, gas and oil, etc.). Allowable costs shall include administrative vehicle expense and regular vehicles expense used for patient care related activities only through documented business miles multiplied by the current mileage rate for the State of South Carolina employees.

Allowable costs shall include the actual costs of specialty vehicles (e.g., vans, trucks). These costs will be classified to the appropriate cost centers for Medicaid cost reporting purposes. Allowable costs would include operation, maintenance, gas and oil, and straight line depreciation (over a 5 year useful life). Should these specialty vehicles be made available for personal use of the facility employees, then that percentage of cost would be reclassified to nonallowable expense.

It is the intent of the SCDHHS to recognize as specialty vehicles, station wagons with a seating capacity of more than six (6) passengers used in patient care related activities, vans, and trucks. The cost of sedans or station wagons with a seating capacity of six (6) or less passengers used for patient transport or other patient care related activities will be limited to the state employee mileage rate and charged to the appropriate cost center(s) based upon miles documented by a log effective August 1, 1986.

For cost reporting requirements prior to August 1, 1986, actual allowable costs which would include operation, maintenance, gas and oil, and straight-line depreciation (over a 5 year useful life and limited to 10,000 maximum vehicle cost) will be used in determining allowable costs for cost centers other than administration. Should these specialty vehicles be made available for personal use of the facility employees, then that percentage of cost would be reclassified to nonallowable expense.

Any vehicle that cannot be identified to charge to the appropriate cost center will be charged to administration and follow administration vehicle allowable cost guidelines. However, only that portion of such costs related directly to patient care related purposes will be allowed.

B) Dues

Association dues will be recognized for reimbursement purposes only when the dues are for professional services that are patient care related.

Any component of association dues related to legal actions against state agencies, lobbying, etc., will not be recognized. All nursing home associations will submit a copy of an audited certified financial statement by an independent accounting firm showing the annual operating cost of the association, and a projected budget to the SCDHHS.

The SCDHHS must approve the independent certified public accounting firm that prepares the certified financial statement. The portion of dues that pertain to litigation against state agencies and lobbying expenses will not be allowed. For the rates established, 90% of this line item will be allowed. However, if by audit it is determined that the portion of dues expended on lobbying, entertaining legislators and legal action against state agencies exceeds 10% of the dues, that amount will be disallowed. The per diem rate for each nursing home that claims association dues will be adjusted at the time costs are determined to be nonallowable and such per diem rate adjustments will be effective for the entire contract period.

C) Legal Fees

Allowable costs include reasonable legal fees and charges (not to exceed $75/hr.) arising from normal, day-to-day business activities related to patient care. Any legal fees recognized must be demonstrated to be necessary for the operation of the facility. Legal fees related to specialized areas, if higher, require prior approval from the SCDHHS. To be approved, rates must be comparable for comparable services. Other legal charges, including, but not limited to, those incurred in administrative appeals and/or litigation involving state agencies, are not allowable cost. However, reasonable legal fees incurred in administrative appeals of audit exceptions may be refundable through a one-time adjustment to the account receivable. The amount of the adjustment shall be determined by the Agency Hearing Panel, upon documentation, but shall not exceed 15% of the amount recovered through appeals or $1,000, whichever is lower. However, in no case will attorney's fees related to litigation or appeals be recognized in determining the prospective per diem rate.

D) Travel

Patient care related travel will be recognized in accordance with South Carolina state employees per diem and travel regulations. Out-of-state travel will be limited to the 48 states located within the continental United States. Further, such out-of-state travel must be either the reasonable allocable portion of cost for chain facilities with out-of-state offices; or (1) be for the purpose of meeting continuing education requirements and (2) must be to participate in seminars or meetings that are approved for that purpose by the South Carolina Board of Examiners for Nursing Home Administrators. Allowable cost for attendance at out-of-state meetings and seminars will be limited to two trips per year per facility. Also, out-of-state travel does not include travel to counties bordering the State of South Carolina. Effective for July 1, 1990 payment rates, travel to the following states/areas are treated as in-state travel, and thus are not subject to the limits on out-of-state travel: Georgia, North Carolina, Washington D.C., and Baltimore, Maryland.

E) Director Fees

Director fees and costs associated with attending board meetings or other top management responsibilities will not be allowed. However travel to and from the directors meetings will be allowed at the per mile rate for state employees and will be limited to in-state travel.

F) Compensation: (Direct and Indirect) (These limits below do not include fringe benefits provided on a non-discriminatory basis.) ALLOWABLE COMPENSATION RANGES FOR OWNERS (LESSORS) AND/OR THEIR RELATIVES AND LESSEES AND/OR THEIR RELATIVES:

JOB TITLE	0-60 BEDS ADJUSTED ANNUAL SALARY	61-99 BEDS ADJUSTED ANNUAL SALARY	100+ BEDS ADJUSTED ANNUAL SALARY
DIRECTOR OF NURSING	$41,502	$45,119	$47,689
RN	35,640	38,908	38,908
LPN	26,562	27,736	27,736
AIDE/ORDERLY	13,567	13,567	13,667
SOCIAL SERVICES DIRECTOR	21,524	22,422	24,841
SOCIAL SERVICES ASSISTANT	15,239	20,750	21,475
ACTIVITY DIRECTOR	16,587	19,903	20,502
ACTIVITY ASSISTANT	14,842	14,842	15,488
DIETARY SUPERVISOR	20,824	22,945	25,715
DIETARY WORKER	13,444	13,444	13,667
LAUNDRY SUPERVISOR	16,887	16,887	19,180
LAUNDRY WORKER	12,346	12,346	12,670
HOUSEKEEPING SUPERVISOR	14,689	20,576	20,901
HOUSEKEEPING WORKER	12,420	12,420	13,044
MAINTENANCE SUPERVISOR	24,542	24,542	25,093
MAINTENANCE WORKER	16,660	18,281	18,531
ADMINISTRATOR	44,719	55,592	65,696
ASSISTANT ADMINISTRATOR	36,565	37,213	37,213
BOOKKEEPER	22,920	22,920	27,185
SECRETARY/RECEPTIONIST	18,207	18,207	18,681
MEDICAL RECORDS SECRETARY	19,528	19,528	19,528

1. The above are maximum limits of allowable compensation to owners and/or relatives who are actually performing these duties 100% of a normal work week. Part-time performance will be computed on percentage of time spent. No individual will have more than one full time equivalent (40 hours per week) job recognized in the Medicaid program.

2. If the facility has under 60 beds, only (1) Administrator and/or Business Manager is allowed.

3. Allowances for any position not specifically listed herein will be based on comparable positions.

4. Other items of consideration to be used in adjustments to these maximum allowances are:

   a. Determination that the job is necessary and that the person is actually there 40 hours per week. (The owner/lessee must document that the job is necessary, and the relative actually worked on the premises the number of hours claimed.)

   b. The time period during which these duties were performed.

   c. Accounting period bed changes based on dates of change.

5. Allowable compensation amounts shown above will be adjusted annually by annual cost of living raises provided to state employees.

G) ALLOWABLE COMPENSATION RANGES FOR OWNERS AND/OR THEIR RELATIVES EMPLOYED BY PARENT COMPANIES

JOB TITLE	0-60 BEDS	61-99 BEDS	100-257 BEDS	258 BEDS or MORE
CEO	$44,719	$55,592	$65,696	*$85,404
MEDICAL DIRECTOR	$40,247	$50,034	$59,127	$76,864
ASST CEO, CONTROLLER, CORPORATE SECRETARY, CORPORATE TREASURER, ATTORNEY	$33,539	$41,696	$49,271	$64,054
ACCOUNTANT, BUSINESS MGR, PURCHASING AGENT, REGIONAL ADMINISTRATOR, REGIONAL V-P REGIONAL EXECUTIVE	$31,305	$38,916	$45,985	$59,781
CONSULTANTS (SOCIAL/ACT), DIETARY (RD), PHYSICAL THERAPIST (RPT), MEDICAL RECORDS (RRA), NURSING (BSRN)	$29,067	$36,136	$42,702	$55,513
SECRETARIES/CLERKS	$18,207	$18,207	$18,681	$18,681
BOOKKEEPERS	$22,920	$22,920	$27,185	$27,185

* 100+ Administrator Salary Guideline plus 30%

1. The above are maximum limits of allowable cost for owners and/or relatives who are actually performing these duties 100% of a normal work week. Part-time performance will be computed according to time spent. No individual will have more than one full time equivalent (40 hour per week) job recognized in the Medicaid program.

2. No assistant operating executive will be authorized for a chain with 257 beds or less.

3. Allowable compensation amounts shown above will be adjusted annually by annual cost of living raises provided to state employees.

H) Management Fee

Only reasonable management fees which result in lower total costs shall be included in allowable costs. Each centrally managed facility shall submit a home office cost report which separately identifies each cost by cost categories. The costs so identified will be individually tested for reasonableness and then assigned to the appropriate line item in the individual facility's cost report.

For purposes of setting the current administrative cost standards, the administrative costs of those centrally managed facilities that reported their management fee as a single line item among administrative costs in their cost report shall be excluded from the computation of the administrative standard. Those centrally managed facilities which identified their management fee as a single line item among administrative costs shall have the management fee included in administrative cost for the purpose of rate calculation.

I) Other Benefits

The other benefits such as pensions, group life insurance, and health insurance can be recognized if these benefits are provided in accordance with sound financial/management practices by the provider. This excludes from allowable cost Key Man Life Insurance and benefits made available only to an exclusive number of employees, including the owner of the facility. Other benefits are accumulated to applicable cost centers.

J) Payroll Taxes and Benefits

Payroll taxes and benefits should be reported in the cost center applicable for the salaries to which they relate. Payroll taxes and benefits will be limited in the same proportion that compensation is limited.

K) Routine Laundry Services

Effective October 1, 1993, basic personal laundry services are to be provided to all patients of the facility free of charge. All laundry costs associated with basic patient personal laundry will be included in allowable costs in the laundry cost center. Basic personal laundry does not include dry cleaning, mending, hand washing or other specialty services; these services need not be provided and residents may be charged for such services if they request them.

L) Specialty Bed Expense

Specialty beds are defined as air fluidized therapy beds and low air loss beds. For rates effective October 1, 1994, specialty bed costs that will be reimbursable under the South Carolina Medicaid nursing facility reimbursement rate will consist of only specialty bed costs for Medicaid recipients in which the nursing facility did not receive reimbursement from the Medicare Program for this service. The specialty bed costs that will be excluded from allowable costs will consist of direct costs only. No indirect costs associated with the removal of specialty bed expense will be removed from allowable costs in order to encourage Medicare participation.

M) Ancillary Services Reimbursement

Ancillary services provided to Medicaid recipients are allowable costs, and thus, reimbursable under both the Medicare and Medicaid Programs. Medicare reimburses these costs outside of the overall routine per diem rate while Medicaid reimburses these costs as a part of the overall routine per diem rate. Ancillary services which are reimbursed by Medicare include: physical therapy, speech therapy, oxygen therapy, occupational therapy, medical supplies, PEN therapy and other special services. Effective January 1, 1995, in order to avoid dual reimbursement of these costs from both the Medicare and Medicaid Programs, the SCDHHS will only include the costs of the Medicaid recipients' ancillary services which are not reimbursed by the Medicare Program in the facility's Medicaid reimbursement rate. However, when ancillary service costs are reimbursed as part of routine costs by Medicare (e.g. PEN Therapy), these costs will continue to be treated as allowable costs in the facility's Medicaid reimbursement rate. Therefore, only those costs which are reimbursed outside of the overall routine per diem rate by Medicare will be removed from allowable costs for Medicaid rate setting purposes. The ancillary services costs that will be excluded from allowable costs will consist of direct costs only. No indirect costs associated with the removal of ancillary services will be removed from allowable costs in order to encourage Medicare participation.

For state operated long term care facilities which are reimbursed retrospectively their total allowable costs, no adjustment to the Medicaid rate will be made to ancillary services (including specialty beds) to adjust for dual reimbursement by both the Medicare and Medicaid Programs. Instead, Medicare Part A and Part B ancillary services cost settlements will be made upon submission of the annual FYE June 30 cost reports in accordance with the cost reporting schedules.

Pursuant to the above, it shall be the responsibility of the provider to bill the Medicare Program for the reimbursement of covered ancillary services provided to dual eligible recipients. Failure to implement billing procedures by January 1, 1995 will result in an adjustment to allowable cost.

N) Eden Alternative Expenses

The costs incurred by nursing facilities which participate in adopting the Eden Alternative concept will be considered an allowable cost for Medicaid rate setting purposes. The goals of the Eden Alternative are to improve the quality of life in nursing facilities, and transform the conventional nursing facility into a vibrant human habitat for its residents. The incorporation of gardens, animals, birds, and children into the daily activities of the nursing facility residents assists in meeting these goals.

As with all other allowable Medicaid costs, these costs will be subject to reasonableness and must be related to patient care. Additionally, Eden Alternative expenses must be offset by grant income. Costs associated with fund raising activities applicable to the Eden Alternative concept or any other fund raising program will not be considered an allowable cost for Medicaid rate setting purposes.